STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G553	A. BUILDING 00 B. WING	03/15/2013

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ARC OF NORTHWEST INDIANA INC, THE	1921 54TH AVE W MERRILLVILLE, IN 46410

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W000000		W000000		

This visit was for a post recertification revisit (PCR) to the investigation of complaint #IN00122535 completed on 01/28/13.

Complaint #IN00122535: Not Corrected.

Dates of Survey: March 11, 12, 13, 14 and 15, 2013.

Facility number: 001067
Provider number: 15G553
AIM number: 100245460

Surveyors:
Claudia Ramirez, RN, Public Health Nurse Surveyor III - Team Leader
Vickie Kolb, RN, BSN, Public Health Nurse Surveyor III

These federal deficiencies also reflect state findings in accordance with 460 IAC 9.

Quality review completed March 25, 2013 by Dotty Walton, Medical Surveyor III.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W000104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. Based on record review and interview, the governing body failed to exercise general policy and operating direction over the facility in a manner to ensure 2 of 2 sample clients (clients A and B), and 1 additional client (client C) had nursing services available to them. Findings include: On 03/12/13 at 2:00 PM a record review of nursing personnel files and nursing contract services of the agency was completed. The records indicated the following: RN (Registered Nurse) #1 was hired 01/07/13. RN #1's timecard indicated she was not actively performing nursing duties or available to staff from 02/13/13 after 11:00 AM until 03/04/13 at 9:00 AM. LPN (Licensed Practical Nurse) #1's last day of employment was 01/24/13. LPN #2's last day of employment was 01/24/13. LPN #3's last day of employment was 02/07/13. A contract with an outside provider for contract nursing services for two LPNs	W000104	Nursing staff was available for consultation during this period. Since the survey, the agency has hired two LPNs on staff and an additional RN to oversee the LPNs, to provide medical care to clients. There is an emergency nursing phone in place to be used in the event that the Nursing staff is not in the office. An RN was contracted on 1/26/13 to conduct medication administration classes and was available for at time of Nursing Manager's absence if needed. The Nursing Manager was hospitalized from 2/13/13 to 2/15/13. During her absence, she took phone calls in the hospital just like she does when she is home. Director of Community Services redistributed non-nursing portion of job to other staff and worked directly with the contracted nurse and temps to assure services according to the standards, policies and procedures. Two LPNs were hired on 3/11/13. On 4/8/13, an RN was hired as Director of Health Services. One LPN position remains open with a temporary nurse filling in until a suitable replacement can be found. So at the present time, The Arc Northwest Indiana employs two RNs, two LPNs, and one temp LPN. All other homes	04/12/2013

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	was signed 02/18/13. Contract LPN #1's first day of service to the agency was 02/19/13. Contract LPN #2's first day of service to the agency was 02/21/13. On 03/13/13 at 11:45 AM an interview with the RN was conducted. The RN indicated she was hired by the agency 01/07/13 and was currently using the services of a contract agency for nursing services along with herself. She indicated she took calls for the agency and was available by pager after hours. She indicated she went on sick leave on 02/13/13 and was in the hospital 2 - 3 days, at which time she did not have a pager and was not available to the agency for work or calls. She indicated the first hours the contract LPN #1 worked was on 02/19/13. The RN indicated after she was hospitalized she took beeper call from home. She indicated she was out of the office on medical leave from 02/13/13 to 03/04/13. She further indicated there was no nursing service available to the agency from 02/13/13 to 02/19/13. 9-3-1(a)		were affected by this dramatic change in nursing staff. These new nurses will serve 54 th and our other group homes. In addition an experienced RN will stay on staff until such time that these new nurses are up to speed with all of the clients care. We now have a contract with a temporary nursing agency so that there is no delay in replacing a nurse should one not be able to fulfill their job duties. In the absence of the Director of Health Services, the Director of Community Services was responsible for assuring policies and procedures and nursing services. The Director of Health Services is taking on this responsibility and is responsible for future monitoring of nursing services.	

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W000122	483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, for 1 of 2 sampled clients (client A), the Condition of Participation: Client Protections was not met. The facility failed to ensure the rights of all clients by failing to implement their policy/procedure which prohibited client neglect for 1 of 2 sampled clients (client A). The facility failed to provide adequate supervision, medical care and evaluations regarding client A's medical condition. Findings include: The facility failed to implement their policy/procedure which prohibited client neglect for 1 of 2 sampled clients (client A). The facility failed to provide adequate supervision, medical care and evaluations regarding client A's medical condition. Please refer to W149. The facility neglected to implement their neglect policy/procedure which prohibits client neglect for 1 of 2 sample clients (client A). The facility neglected to provide appropriate supervision and timely medical evaluation for client A after a change in her medical condition. The facility neglected to protect client A from injury resulting in a foot fracture the	W000122	Behavioral Health Director will review reporting requirements of Abuse, Neglect and Exploitation of clients with the Service Coordinator and DSPs and document this review. To monitor for continued compliance the Service Coordinator and/or Community Services Nurse will observe and monitor all incident reports and daily logs as they are submitted. The Behavior Health Director will review reporting and investigation requirements for Abuse Neglect, and Exploitation of clients with the Service Coordinator and DSPs that are involved with 54 th Ave by 4/25/13. In order to identify other areas of concern all other Coordinators will be trained on reporting and investigation requirements for Abuse Neglect, and Exploitation. In order to prevent reoccurrences posters explaining client rights and reporting requirement will be made and distributed to all group homes and the day program so that staff and clients become more aware of the requirements on an ongoing basis. Additionally all staff will be trained on reporting and investigation requirements for Abuse Neglect, and Exploitation at	04/12/2013

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	agency could not explain, neglected to provide timely medical care/treatment for evaluation of injury and unknown medical problems to her left side and right foot pain problems. 9-3-2(a)		least annually unless changes occur or need requires this to be done more frequently. To ensure that Service Coordinators are trained on reporting and investigation requirements for Abuse Neglect, and Exploitation the Behavioral Health Director will review their training records at least annually and document review of findings. Area Managers will review DSP training records to ensure they have been training at least annually and document review of findings. All new Service Coordinators and DSPs will be trained on reporting and investigation requirements for Abuse Neglect, and Exploitation prior to working a home or with a client. In addition, the Service Coordinators will be present in their homes at least two times per month to ensure protection of clients, address concerns, monitor activities, etc. Documentation of visits will be completed and will include specifics to the client as well as the visit. The Behavioral health Director will review progress notes regularly.	

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W000149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 2 of 3 BDDS (Bureau of Developmental Disabilities Services) reports regarding client protection, the facility neglected to implement the facility's policy and procedure prohibiting client neglect by neglecting/failing to provide appropriate supervision to 1 of 2 sample clients (client A), neglected to protect client A from injury resulting in a foot fracture the agency could not explain, neglected to provide timely medical care/treatment for evaluation of injury and unknown medical problems to her left side and right foot pain problems. Findings include: On 03/11/13 at 2:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and indicated the following: 1. A BDDS report dated 02/26/13 indicated: "[Client A] had an appointment to see Dr (doctor) [name], a neurologist at [hospital name] due to physical change. Dr [name] admitted [client A] to perform a series of tests to determine a diagnosis. [Client A]	W000149	Behavioral Health Director will review reporting requirements of Abuse, Neglect and Exploitation of clients with the Service Coordinator and DSPs and document this review. To monitor for continued compliance the Service Coordinator and/or Community Services Nurse will observe and monitor at least monthly. Service Coordinator and/or Community Services Nurse will retrain all staff for all medical supervision with regards to immediately identifying and reporting in a timely manner any change in consumer's appearance. To monitor for continued compliance the QMRP or Community Services Nurse will review daily logs daily, and document any issues in clients' medical file.	04/12/2013

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	remains in the hospital. [Client A] seems to be in fair condition." 2. A BDDS report dated 03/05/13 indicated: "The Service Coordinator (SC) called [hospital] where [client A] is being treated to get a status update. The nurse informed the Service Coordinator that [client A's] diagnosis was multiple right toe fracture to the 2nd, 3rd, and 4th toes. The nurse also informed me (SC) that [client A's] right foot has a mild fracture." Plan to Resolve: "[Client A] does remain in the hospital at this time. The nurse informed me for treatment that the doctor orders are to place a boot on [client A's] left leg and order her a mobilization device to utilize to walk and for the right foot to allow it to heal on its own. An investigation has been initiated for unknown origin." The Investigation Fact Sheet Summary for the 03/05/13 incident and Conclusion dated 03/08/13 indicated: "All staff at Day Services (agency's own day program) & (sic) all staff at group home reports no abuse or aggression toward client. There has been no report at Day Services that injuries to client's (A's) foot were noticed, however, staff noticed signs but it was believed by staff that there were problems with her left side per Developmental Specialist who denies informing staff of			

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	issue. [Staff #1] noticed injuries to client's foot, reported the problem to Service Coordinator & completed incident report. The problem with the left foot & additional limping occurred after the client left home the morning of 02/25/13, but before she returned home from Day Service on 02/25/13." Conclusion: "It is my belief that [client A] sustained her injuries at Day Service on 02/25/13, however, the cause of the injuries CANNOT be determined. Staff failed to report signs of injury to Health & Safety Tech & management when consumer was demonstrating signs of pain by pointing to foot on 02/25/13." Recommendations: "Staff will be given training on recognizing signs of injury. The client pointed at foot and no one realized something was wrong. Client sits most of day at workshop." The Investigation dated 03/08/13 contained Interview Fact Sheets of statements taken of the staff who had worked with client A. The dated statements contained the following information: 03/05/13: Day Service (DS) staff #2 wrote, "Most of February I noticed that [client A] was wetting herself at least 3 times throughout the day. [Client A] never use (sic) to do this. I was the main			

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	one changing her because she was most familiar with me. The last day I saw [client A] was when she went on her doctor's appointment...." 03/06/13: DS staff #1 wrote, "Last time I saw [client A] was about a week & half (sic) ago. (I don't remember the exact date)...The only problem I noticed, was [client A] using the bathroom more on herself. Staff reported that to the Health & Safety Tech...." 03/08/13: DS staff #1's addendum indicated, "1. Staff (unidentified) said that [client A] was using the bathroom on herself, but they told [name] the Health & Safety Tech. The staff that work with [client A] reported the peeing [urinating] on self to Health & Safety Tech. 2. The Health & Safety Tech noticed that she was not using her left side, and said that she is going to call the service coord[inator] and find out why she wasn't using the left side. No I did not tell a staff that something was going on with her left side. The Health & Safety Tech was the one that noticed [client A] not using left side...4. The staff will notify the Health & Safety Tech if there are changes in behavior, or any injuries...8. I don't know who told staff about her left side. 9. I oversee the group hab (habilitation), I have four rooms I go between all day, attend meetings, I am not in one room all			

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	day. I bounce between four different rooms. 10. It is my responsibility to make sure staff do what they are suppost (sic) to...." 03/06/13: Heath & Safety Tech (HST) wrote, "Did not notice that [client A] was walking funny but was concern (sic) that she was urinating on herself, which is not [client A]...." 03/08/13: HST Addendum indicated, "... [Service Coordinator] said she has an appointment to go to the doctor on Wednesday (02/26/12) and [staff #3] ask me if I had a script (order) from the doctor for a UTI (Urinary Tract Infection) and I said no but I was concern (sic). As for documenting or writing an incident report, I blame myself for not writing one. I just want (sic) to see if I can get the care done for her right away. No one told me that [client A] was pointing at her feet...." 03/05/13: DS #4 wrote, "...last time I work (sic) with [client A] was Monday 02-25-13. Staff notice (sic) something was wrong with her. She didn't wanna walk or go to the bathroom. Staff ask (sic) supervisor what was going on, she said [DS staff #1] some one said that she (client A) wasn't using her left side. So when I work with her I'll put her and (sic) a wheelchair so we both wouldn't fall (sic). This has been going on I think for 2			

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	weeks...Staff noticed something was going on with her because she kept using the bathroom on herself. Friday or Monday (02/22/13 or 02/25/13) [client A] was crying pointing (sic) her feet (sic) when I got over there I saw that she was wet and that her socks was to to (sic). I notice (sic) she was walking funny. [DS staff #1] said something was going on with her left side...[client A] gets drop (sic) and pick (sic) up by home staff...." 03/06/13: Group Home (GH) staff #1 wrote, "...Monday morning (02/25/13) she (client A) left for workshop (day service), she was walking her normal unsteady gait and when I picked her up the staff at the workshop brought her out in a wheelchair and when I stood her up to walk to the van she was limping on her left foot. When she got back to the group home I assisted her into the house. I let her go to close the door and she attempted to walk and fell with the first step. I helped her up and sat her down in a chair an took (sic) off her coat and shoes. She sat and did not move until dinnertime when I stood her up and as soon as she stepped on her left foot she fell again. I helped her up to the dinner table so she could eat then I called the service coordinator to ask her if it had been reported that she fell at the workshop that morning and she said no. She (SC) told me to do an incident			

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	report about her falls and that she would check on it the next day with the workshop staff and that [client A] had an appointment the next day and she would have the doctor check her out. Also [client A] has fallen once prior to this back in November. When things happen at the workshop (day service) there is no communication between the group home and workshop as to what happens and what took place and what the end result is...During the week when she is at home she rarely has any accidents on herself except at night when she is asleep at night. Workshop staff says that she has an accident just about everyday on herself. Wen I picked her up (sic) at the workshop on Feb. 25, 2013 the staff that brought her out said that [client A] had an accident on herself and that she kept grabbing at her shoe. When I put her to bed Monday night (02/25/13) her left foot looked fine, but when we were at the hospital (02/26/13) and I was getting her undressed I noticed bruises on the bottom of her feet and had them do an x-ray and that's when they found it to be broken or fractured toes on her left foot. I honestly think that what ever happened it happened at the workshop. On Monday night (02/25/13) when I put her to bed I looked at her foot and it appeared to be fine but as I touched in certain places like the ball of her foot she would snatch her foot			

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	away from me." GH staff #1 failed to call the nurse on 02/25/13 to inform her of the falls, or client A's change in status, from when she saw her the morning of 02/25/13, to when she came home from day service on 02/25/13 in the PM. 03/06/13: Service Coordinator written statement indicated, "...I contacted [HST]. [HST] informed me that she has not been informed from any staff that [client A] has fallen. She did state that when it's time for medication, [client A] refuses to walk so the staff gets (sic) a wheelchair and pushes her to take her medication...." 03/07/13: SC Addendum indicated, "The 02/26/13 appointment was made due to physical issues. Wanted to get her checked out because she was having difficult (sic) using left hand & urinating on herself and refusing to do anything. On 02/25/113 Day Services wanted a UTI cup because she [client A] kept urinating on self at day service. [HST] was the person requesting the cup, but never did test because of doctor's appointment. There is no Incident Report stating this information." An Incident/Accident Report dated 02/25/13 and timed at 4:50 PM and 7:45 PM written by GH staff #1 indicated, "Client was limping when I picked her up			

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	15G553	A. BUILDING 00 B. WING	03/15/2013

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	from the workshop and when we got to the group home, she was not putting any weight on her left foot and fell when she tried to twice yesterday evening." The form contained the questions, "What did you do about this Incident/Accident?" GH staff #1 wrote, "called the service coordinator and did an incident report." GH staff #1 did not contact the nurse to report the two falls or client A's inability to bear weight on her left foot. Client A's records were reviewed on 03/12/13 at 10:58 AM. Client A's ISP (Individual Support Plan) dated 01/14/13 indicated she was at risk for falls and had a fall risk plan. The risk plan indicated, "...Contact the Nurse for further instructions even if unsure an injury has occurred...." Client A's record contained the following dated documents: 02/07/13: Cumulative Medical Record indicated, "Received report from day services that [client A] urinated on herself a couple (sic) times yesterday. U/A (urine test) being done." The entry was signed by LPN #2 on her last day of employment. The next entry was dated 02/21/13 and indicated, "[Client A] refused neuro (neurology) follow-up appointment today. Rescheduled for 03/07/13."			

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	02/07/13: Order from MD (Medical Doctor) for Urinalysis with C & S (Culture & Sensitivity) if indicated. Dx (diagnosis) UTI (Urinary Tract Infection). 02/12/13: Order from client A's MD indicated the lab results (UA) was, "Abnormal but not significant - Recommendations: Push p.o. (oral) fluids if not on any fluid restriction." Client A's record did not indicate the nurse reviewed this order or carried out this order. The record contained no documentation by a nurse related to this order. 02/26/13: Cumulative Medical Record indicated, "Admitted to [hospital]." The Hospital Record contained the following documented information: 02/26/13: X-Ray - Foot/complete - Impression: Nondisplaced fractures involving the bases of the second, third and fourth metatarsals. There is mild impaction of the fracture fragments." 02/27/13: History and Physical indicated, "This is a patient I saw yesterday in my office and sent to the emergency room because the patient's caregiver told me that she was having some problems getting up and walking. She was also feeling somewhat weak on the left side,			

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	so she was admitted for further evaluation...The patient was admitted for further evaluation and now the patient was thought to have left ankle fracture on an x-ray of the ankle, which was a nondisplaced fracture involving the base of the second, third, and fourth metatarsals. There is mild impaction of the fracture fragment also. The patient is admitted for further evaluation...Impression: This is a ...patient who has several problems: 1. A left ankle fracture. 2. Left-sided weakness. It could be a stroke versus cervical degenerative joint disease related. Recommendation: My recommendation is to look at the MRI (Magnetic Resonance Imaging) of the brain and cervical spine, and then for the ankle fracture the patient is going to be seen by an orthopedic doctor." 02/27/13: Podiatry Consult Note: "This is a [age] female with non displaced fractures of the left foot...The 2nd metatarsal appears to be impacted at the fracture site and it is non displaced. It is an unstable fracture but will do well conservatively if the patient is non weight bearing for 6-8 weeks. 03/03/13 - PT (Physical Therapy) Evaluation indicated client A was bed ridden and weight bearing status was			

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	non-weight bearing. The evaluation indicated follow-up PT was required and "Other Goal: To maintain functional ROM (Range of Motion of LEs (Lower Extremities). To assist in pt's (patient's) positioning to prevent pressure ulcers development...." 03/04/13: Rehabilitation Evaluation/Preadmission Screening For Rehab Admission: "History of Present Illness: "...admitted on 02/26/13 for possible new CVA (Cerebrovascular Accident) (stroke). He referred the patient to the emergency room where she was evaluated, noted to have right fullness leg erythema (redness of the skin) with some swelling but had neuro exam was unremarkable. She had an x-ray of that right (sic) foot (left) area that demonstrated some multiple fracture of the metatarsals. She was however admitted for TIA (Transient Ischemic Attach) (loss of blood flow to a part of the brain) rule out CVA...Patient was referred to me for rehabilitation evaluation and further rehabilitation management because the patient was weak and not able to walk and not able to do activity of daily living...This patient does not meet rehab admission criteria. Discharge plan: home with family. The patient requires: Physical Therapy, Occupational Therapy and Speech Therapy...."			

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	03/06/13: Discharge Summary: "Admit date: 02/26/13. Admitting Diagnosis: Cellulitis. Discharge Diagnosis: Multiple L (left) metatarsal (toe) fractures. Treatment & Course in Hospital With Complications If Any: Pt (patient) was admitted and orthopedic consultation made, and recommendations carried out. Pt has done [not legible] and now has appropriate immobilization device to her left foot and will be dc (discharged) with home health PT/OT (Physical Therapy/Occupational Therapy) at home. Disposition: DC to group home. Discharged 03/06/13." Client A was discharged with a prescription order from the hospital ordering PT/OT therapy. The hospital faxed the group home instructions which indicated, "will need OT/PT for home. Staff to transport at 6:00 PM." 03/06/13: Cumulative Medical Record indicated, "Discharged from [hospital]. Returned to group home." 03/07/13: Cumulative Medical Record written by contract nurse indicated, "Writer arrived at group home to assess patient...Pain noted to bilat (bilateral) (both) feet...Boot applied to L (left). Assist with transfers by DSP (Direct Support Staff)...N.O. (New Order) for			

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	PT/OT Therapy. On 03/11/13 at 2:30 PM, a review of the facility's 02/15/12 Policy For Handling Cases of Neglect and Abuse indicated, "The ARC Northwest Indiana prohibits all abuse, neglect and exploitation of our clients. Staff will immediately report any allegations of abuse, neglect or exploitation of our clients per agency reporting procedure. The ARC Northwest Indiana will meet current regulatory requirements for reporting all incidents. All allegations of abuse, neglect, humiliation or exploitation will be investigated per The ARC Northwest Indiana's investigation process while protecting the individual...Neglect - is defined as failure to consider and provide for the safety or care of the client and anticipate and remedy the placing of a client in a situation that poses a threat to his/her health and well-being. Examples include, but are not limited to, depriving a client of food, drink, clothing, sleep, shelter, use of bathroom facilities, or medical care/treatment, seclusion by placing an individual alone in a room or other area from which exit is prevented; not providing adequate personal care, leaving clients unsupervised, etc...all deaths that occur within ARC Bridges, Inc. (same as ARC Northwest Indiana) services will be treated as suspected			

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	abuse/neglect and investigations will be conducted...Internal investigation refers to a situation that can be successfully addressed within the department (Possible examples include a staff person accused of calling a client a name or an injury of unknown origin that can be traced to an incident documented on daily logs...Internal investigations should follow the same procedures with regards to paperwork and distribution. Because they are still reported to all the State agencies and are discussed with the Quality Systems Director or designee, there is no chance they can be ignored)...injuries of unknown origin are treated as an allegation of abuse or neglect." An interview with the RN (Registered Nurse) was conducted on 03/13/13 at 12:22 PM. The RN indicated staff should have contacted the nurse when the client arrived home on 02/25/13 when she was limping. She further indicated there were numerous incidents that night which should have alerted the staff to call the nurse. She indicated staff were to contact the nurse when the client has a change of status. Client A had a change of status when she arrived home limping after day service, when she fell twice, when she would not bear weight on her foot and when she pulled her foot away when staff			

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	touched it. The RN indicated day service staff should have reported the problems with client A's left side to the nurse as it could indicate she might have had a stroke. She indicated staff did not have to know what was wrong with the clients, they were to simply report a change. Day service and group home staff neglected to report those changes. The RN indicated the nurse who saw client A in the group home the day after she was discharged failed to define how staff were to transfer client A or to obtain orders on how to transfer client A safely with her fractures. There were no instructions for staff regarding client A's care regarding bathing, toileting, bed or transfers from one place to another. The nurse neglected to ensure client A's needs were met by obtaining PT/OT Therapy. The RN indicated staff failed to follow the facility policy and procedure on abuse and neglect when they neglected to report client A's condition on 02/25/13. The RN indicated based on the information surrounding the facts on 02/25/13, client A should have been seen by a medical person on that day and should not have waited until a scheduled appointment the next day. 9-3-2(a)			

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W000192	483.430(e)(2) STAFF TRAINING PROGRAM For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. Based on observation, record review and interview, the facility failed to train direct care staff on appropriate transfer methods(non weight bearing body repositioning) for 1 of 2 sampled clients (client A). Findings include: Observations at the group home were conducted on 03/11/13 from 4:30 PM until 6:45 PM. Client A was observed to be pushed by staff #3 into the group home in a wheelchair. Client A was assisted with one staff (staff #2 and staff #3) to each side and she stood on her left foot and staff turned her towards the couch	W000192	The Community Service Nurse has trained DSPs on proper transfer methods(non weight bearing body repositioning) for client A. Staff has been trained on client's risk plans, as well as assessing for pain. To ensure further compliance the Community Services Nurse and/or Service Coordinator will visit group home weekly for three months and at least bi-monthly thereafter to monitor risk plan implementation.	04/12/2013

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	and she sat down on the couch. The QMRP gave staff #2 and #3 verbal instructions on how to transfer the client from the wheelchair to the couch using the typed document, "How to Perform a Two-Person Transfer From a Wheelchair." Client A sat on the couch until she was assisted by staff #2 and staff #3 to stand up, bearing weight on her right foot, and she sat down in the wheelchair and was wheeled to the kitchen table for supper. Staff #2 was interviewed on 03/11/13 at 4:20 PM. She indicated she had not worked at this house for awhile and was not the usual staff. She indicated she had not worked with client A since she had returned home from the hospital with the boot immobilizer (for her foot fracture) on her left leg. Staff #3 was interviewed on 03/11/13 at 5:00 PM. She indicated she was not the usual staff at the home and she usually drove the clients to medical appointments. She indicated she had not worked with client A since she had returned home from the hospital with the boot immobilizer on her left leg. A record review was conducted on 03/11/13 at 5:30 PM, of the undated, "How to Perform a Two-Person Transfer			

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	From a Wheelchair" gave the following instructions: "Performing a two-person transfer from a wheelchair can be a tricky process...The more people helping, the better, although two is a safe minimum...Hold the person under her arms while standing next to her. Left the person using you legs, not your back. When you have transferred the weight from the wheelchair to yourself, move the chair out of the way. If you have someone helping you, they can do this task...twist round to transfer the person onto or into the object they are being moved to...." The document did not indicate what person #1 or person #2 were to specifically do. The document failed to indicate the client should not bear weight. The QMRP (Qualified Mental Retardation Professional) was interviewed on 3/11/13 at 6:06 PM. The QMRP indicated the nurse had seen client A in the home the day after she was discharged from the hospital. She indicated the nurse did not leave any instructions on how staff were to transfer and care for client A and her fractures. She indicated the 03/06/13 hospital discharge information did not provide any information for transfers either. She indicated the hospital information indicated client A's left foot had fractures which were immobilized by a boot immobilizer. She			

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	indicated she had been contacted by the hospital prior to discharge and the hospital indicated client A had fractures on both the left and right sides and was not to bear weight to promote healing. She indicated client A needed OT(Occupational Therapy) and PT (Physical Therapy) appointments after discharge and the nurse had not arranged those yet. She indicated she received no written instructions/training from anyone on how client A should be transferred, bathed or toileted and she developed a written "How to Perform a Two-Person Transfer From a Wheelchair" after watching a video given to her by the agency training department since no written policy/procedure existed. This federal tag relates to complaint #IN00122535. This deficiency was cited on 01/28/2013. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-3(a)			

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W000210	483.440(c)(3) INDIVIDUAL PROGRAM PLAN Within 30 days after admission, the interdisciplinary team must perform accurate assessments or reassessments as needed to supplement the preliminary evaluation conducted prior to admission. Based on observation, record review and interview, the facility failed to assess the transfer needs (non weight bearing repositioning of her body) of client A in regards to her ADLs/activities of daily living, (bathing, dressing, toileting) after a change in her physical status/foot fractures for 1 of 2 sampled clients (client A). Findings include: Observations at the group home were conducted on 03/11/13 from 4:30 PM until 6:45 PM. Client A was observed to be wheeled into the group home by staff #3 in a wheelchair. Client A was assisted with one staff (staff #2 and staff #3) to each side and she stood on her left foot and staff turned her towards the couch	W000210	Upon discharge from hospital the IDT will meet within 30 days to assess changes in programming and medical treatment. To ensure future compliance any changes in client condition will be evaluated by the team or the appropriate professional based on the presenting change within 2 days of knowledge.	04/12/2013

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	and she sat down on the couch. The QMRP (Qualified Mental Retardation Professional) gave staff #2 and #3 verbal instructions on how to transfer the client from the wheelchair to the couch using the undated typed document, "How to Perform a Two-Person Transfer From a Wheelchair." Client A sat on the couch until she was assisted by staff #2 and staff #3 to stand up, bearing weight on her right foot and sat down in the wheelchair and was wheeled to the kitchen table for supper. Staff #2 was interviewed on 03/11/13 at 4:20 PM. She indicated she had not worked at this house for awhile and was not the usual staff. She indicated she had not worked with client A since she had returned home from the hospital with the boot immobilizer (for the foot fractures) on her left leg. Staff #3 was interviewed on 03/11/13 at 5:00 PM. She indicated she was not the usual staff at the home and she usually drove the clients to medical appointments. She indicated she had not worked with client A since she had returned home from the hospital with the boot immobilizer on her left leg. A record review was conducted on 03/11/13 at 5:30 PM, of the undated,			

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	"How to Perform a Two-Person Transfer From a Wheelchair" which gave the following instructions: "Performing a two-person transfer from a wheelchair can be a tricky process...The more people helping, the better, although two is a safe minimum...Hold the person under her arms while standing next to her. Left the person using you legs, not your back. When you have transferred the weight from the wheelchair to yourself, move the chair out of the way. If you have someone helping you, they can do this task...twist round to transfer the person onto or into the object they are being moved to...." The document did not indicate what person #1 or person #2 were to specifically do. The document failed to indicate the client should not bear weight. The QMRP (Qualified Mental Retardation Professional) was interviewed on 3/11/13 at 6:06 PM. The QMRP indicated the nurse had seen client A in the home the day after she was discharged from the hospital. She indicated client A was hospitalized from 02/26/13 and discharged 03/06/13. She indicated the nurse did not leave any instructions on how staff were to transfer and care for client A and her fractures. She indicated the 03/06/13 hospital discharge information did not provide any information for transfers either. She			

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	indicated she had been contacted by the hospital prior to discharge and the hospital indicated client A had fractures on both the left and right sides and was not to bear weight. She indicated client A needed OT and PT appointments upon discharge (for adaptive equipment needs/methods for ADL skills) and the nurse had not arranged those yet. She indicated she received no written instructions from anyone on how client A should be transferred (moved from position to position) safely, bathed or toileted and she developed a written "How to Perform a Two-Person Transfer From a Wheelchair" after watching a video given to her by the agency training department since no written policy/procedure existed. An interview with the RN (Registered Nurse) was conducted on 03/14/13 at 10:22 AM. The RN indicated client A's transfer needs had not yet been assessed and an OT/PT appointment was not scheduled until 03/27/13 at 10:30 AM. This federal tag relates to complaint #IN00122535. This deficiency was cited on 01/28/2013. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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W000318	483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met.	W000318	Community Service Nurse will address all medical issues in regards to clients needs. To ensure future compliance Community Service Nurse will observe and assess all medical issues that are brought to their attention as needed on an ongoing. An RN was contracted on 1/26/13 to conduct medication administration classes and was available for at time of Nursing Manager's absence if needed. The Nursing Manager was hospitalized from 2/13/13 to 2/15/13. During her absence, she took phone calls in the hospital just like she does when she is home. Director of Community Services redistributed non-nursing portion of job to other staff and worked directly with the contracted nurse and temps to assure services according to the standards, policies and procedures. Two LPNs were hired on 3/11/13. On 4/8/13, an RN was hired as Director of Health Services. One LPN position remains open with a temporary nurse filling in until a suitable replacement can be found. So at the present time, The Arc Northwest Indiana employs two RNs, two LPNs, and one temp LPN. All other homes were affected by	04/12/2013

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			this dramatic change in nursing staff. These new nurses will serve 54 th and our other group homes. In addition an experienced RN will stay on staff until such time that these new nurses are up to speed with all of the clients care. We now have a contract with a temporary nursing agency so that there is no delay in replacing a nurse should one not be able to fulfill their job duties. In the absence of the Director of Health Services, the Director of Community Services was responsible for assuring policies and procedures and nursing services. The Director of Health Services is taking on this responsibility and is responsible for future monitoring of nursing services. When a consumer is hospitalized the Community Services Nurse in coordination with the Service Coordinator will develop plans to address any changes in condition. A meeting will be held within 24 hours prior to or following discharge with the day program and others relevant to the client's care and document team discussion and approvals if necessary. To prevent reoccurrence, this will be done for all consumers returning home after hospitalization as a standard practice.	

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	Based on observation, record review and interview, the Condition of Participation: Health Care Services was not met. The facility failed to ensure adequate health care services were available for 1 of 2 sampled clients (client A). The facility failed to ensure their nursing services were available to train direct care staff, secure evaluations, write methodologies, implement doctor's orders and supervise medication administration so as to assure client A received timely health care services for her condition after a change in her physical status/fractures. Findings include: The facility failed to ensure their nursing services were available to train direct care staff, secure evaluations (Occupational/Physical Therapy), write methodologies, implement doctor's orders and supervise medication administration so as to assure client A received timely health care services after a change in her physical status/fractures. 1. Please refer to W192 as the facility's		The Behavior Health Director or the Community Services Operations Director will hold a weekly meeting to review changes in client status and ensure these meetings are scheduled or have been completed and document this discussion.	

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	nursing staff failed to train direct care staff on appropriate non-weight bearing transfer methods (moving from position to position safely) for 1 of 2 sampled clients (client A). 3. Please refer to W210 as the facility's nursing staff failed to assess/reassess the transfer needs (non-weight bearing movement from position to position) and provide OT/PT (Occupational Therapy/Physical Therapy) assessments in regards to her activities of daily living, (bathing, dressing, toileting) after the change of physical status and foot fractures for 1 of 2 sampled clients (client A). 4. Please refer to W331 as the facility failed to provide adequate nursing services: 1. To assess and verify medical information received from the hospital and provide staff training in regards to a method of transferring 1 of 2 sampled clients (client A) without causing injury to the client. 2. To ensure PT/OT was available as ordered for 1 of 2 sampled clients (client A). 3. To provide adequate documentation for the use of PRN (as needed) medications when new medications are ordered for 1 of 2 sampled clients (client			

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	A). 4. To ensure physician's orders are carried out (push fluids) and documented for 1 of 2 sampled clients (client A). 5. Please refer to W368 for the facility's failure for 1 of 2 sampled clients (client A), to ensure medications were administered as ordered. This federal tag relates to complaint #IN00122535. This deficiency was cited on 01/28/2013. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			

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W000331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs.	W000331	Nursing services will be involved in developing systems for monitoring and training staff on following physician's order when released from the hospital. Nursing services will train on the following: Transferring and transporting clients safely, medical signs and symptoms, reporting changes in client condition, and documenting the use of PRN medications. To ensure future compliance all new staff will be trained on these topics and all staff will be retrained annually. The area manager will ensure that staff training records are up to date. An RN was contracted on 1/26/13 to conduct medication administration classes and was available for at time of Nursing Manager's absence if needed. The Nursing Manager was hospitalized from 2/13/13 to 2/15/13. During her absence, she took phone calls in the hospital just like she does when she is home. Director of Community Services redistributed non-nursing portion of job to other staff and worked directly with the contracted nurse and temps to assure services according to the standards, policies and procedures. Two LPNs were hired on 3/11/13. On 4/8/13, an RN was hired as Director of Health Services. One LPN position remains	04/12/2013

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			open with a temporary nurse filling in until a suitable replacement can be found. So at the present time, The Arc Northwest Indiana employs two RNs, two LPNs, and one temp LPN. All other homes were affected by this dramatic change in nursing staff. These new nurses will serve 54 th and our other group homes. In addition an experienced RN will stay on staff until such time that these new nurses are up to speed with all of the clients care. We now have a contract with a temporary nursing agency so that there is no delay in replacing a nurse should one not be able to fulfill their job duties. In the absence of the Director of Health Services, the Director of Community Services was responsible for assuring policies and procedures and nursing services. The Director of Health Services is taking on this responsibility and is responsible for future monitoring of nursing services. When a consumer is hospitalized the Community Services Nurse in coordination with the Service Coordinator will develop plans to address any changes in condition. A meeting will be held within 24 hours prior to or following discharge with	

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	Based on record review and interview, the facility failed to provide adequate nursing services: 1. To assess, verify medical information received from the hospital, provide sufficient staff, and provide staff training in regards to a method of transferring 1 of 2 sampled clients (client A) without causing injury to the client. 2. To ensure PT/OT (Physical/Occupational Therapy) were available as ordered for 1 of 2 sampled clients (client A). 3. To provide adequate documentation for the use of PRN (as needed) medications when new medications were ordered for 1 of 2 sampled clients (client A). 4. To ensure physician's orders were carried out (push fluids) and documented for 1 of 2 sampled clients (client A). Findings include:		the day program and others relevant to the client's care and document team discussion and approvals if necessary. To prevent reoccurrence, this will be done for all consumers returning home after hospitalization as a standard practice. The Behavior Health Director or the Community Services Operations Director will hold a weekly meeting to review changes in client status and ensure these meetings are scheduled or have been completed and document this discussion.	

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	1. 2. On 03/11/13 at 2:15 PM a record review of the BDDS (Bureau of Developmental Disabilities Services) reports was completed and indicated the following: A BDDS report dated 02/26/13 indicated: "[Client A] had an appointment to see Dr (doctor) [name], a neurologist at [hospital name] due to physical change. Dr [name] admitted [client A] to perform a series of tests to determine a diagnosis. [Client A] remains in the hospital. [Client A] seems to be in fair condition." A BDDS report dated 03/05/13 indicated: "The Service Coordinator (SC) called [hospital] where [client A] is being treated to get a status update. The nurse (hospital nurse) informed the Service Coordinator that [client A's] diagnosis was multiple right toe fracture to the 2nd, 3rd, and 4th toes. The nurse also informed me (SC) that [client A's] right foot has a mild fracture." Plan to Resolve: "[Client A] does remain in the hospital at this time. The nurse informed me for treatment that the doctor orders are to place a boot on [client A's] left leg and order her a mobilization device to utilize to walk and for the right foot to allow it to heal on its own. An investigation has been initiated for unknown origin."			

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	The Investigation Fact Sheet Summary and Conclusion of the 03/05/13 incident, dated 03/08/13 indicated: "All staff at Day Services (agency's own day program) & (sic) all staff at group home reports no abuse or aggression toward client. There has been no report at Day Services that injuries to client's (A's) foot were noticed, however, staff noticed signs but it was believed by staff that there were problems with her left side per Developmental Specialist who denies informing staff of issue. [Staff #1] noticed injuries to client's foot, reported the problem to Service Coordinator & completed incident report. The problem with the left foot & additional limping occurred after the client left home the morning of 02/25/13, but before she returned home from Day Service on 02/25/13." Conclusion: "It is my belief that [client A] sustained her injuries at Day Service on 02/25/13, however, the cause of the injuries CANNOT be determined. Staff failed to report signs of injury to Health & Safety Tech & management when consumer was demonstrating signs of pain by pointing to foot on 02/25/13." Recommendations: "Staff will be given training on recognizing signs of injury. The client pointed at foot and no one realized something was wrong. Client sits most of day at workshop."			

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	The Investigation dated 03/08/13 contained Interview Fact Sheets of statements taken of the staff who had worked with client A. The dated statements contained the following information: 03/05/13: Day Service (DS) staff #2 wrote, "Most of February I noticed that [client A] was wetting herself at least 3 times throughout the day. [Client A] never use (sic) to do this. I was the main one changing her because she was most familiar with me. The last day I saw [client A] was when she went on her doctor's appointment...." 03/06/13: DS staff #1 wrote, "Last time I saw [client A] was about a week & half (sic) ago. (I don't remember the exact date)...The only problem I noticed, was [client A] using the bathroom more on herself. Staff reported that to the Health & (and) Safety Tech...." 03/08/13: DS staff #1's addendum indicated, "1. Staff (unidentified) said that [client A] was using the bathroom on herself, but they told [name] the Health & Safety Tech. The staff that work with [client A] reported the peeing on self to Health & Safety Tech. 2. The Health & Safety Tech noticed that she was not using her left side, and said that she is			

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	going to call the service coord[inator] and find out why she wasn't using the left side. No I did not tell a staff that something was going on with her left side. The Health & Safety Tech was the one that noticed [client A] not using left side...4. The staff will notify the Health & Safety Tech if there are changes in behavior, or any injuries...8. I don't know who told staff about her left side. 9. I oversee the group hab (habilitation), I have four rooms I go between all day, attend meetings, I am not in one room all day. I bounce between four different rooms. 10. It is my responsibility to make sure staff do what they are suppost (sic) to...." 03/06/13: Heath & Safety Tech (HST) wrote, "Did not notice that [client A] was walking funny but was concern (sic) that she was urinating on herself, which is not [client A]...." 03/08/13: HST Addendum indicated, "... [Service Coordinator] said she has an appointment to go to the doctor on Wednesday (02/26/12) and [staff #3] ask me if I had a script (order) from the doctor for a UTI (Urinary Tract Infection) and I said no but I was concern (sic). As for documenting or writing an incident report, I blame myself for not writing one. I just want (sic) to see if I can get the care done for her right away. No one told me			

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	that [client A] was pointing at her feet...." 03/05/13: DS #4 wrote, "...last time I work (sic) with [client A] was Monday 02-25-13. Staff notice (sic) something was wrong with her. She didn't wanna walk or go to the bathroom. Staff ask (sic) supervisor what was going on, she said [DS staff #1] some one said that she (client A) wasn't using her left side. So when I work with her I'll put her and (sic) a wheelchair so we both wouldn't fall (sic). This has been going on I think for 2 weeks...Staff noticed something was going on with her because she kept using the bathroom on herself. Friday or Monday (02/22/13 or 02/25/13) [client A] was crying pointing (sic) her feet (sic) when I got over there I saw that she was wet and that her socks was to to (sic). I notice (sic) she was walking funny. [DS staff #1] said something was going on with her left side...[client A] gets drop (sic) and pick (sic) up by home staff...." 03/06/13: Group Home (GH) staff #1 wrote, "...Monday morning (02/25/13) she (client A) left for workshop (day service), she was walking her normal unsteady gait and when I picked her up the staff at the workshop brought her out in a wheelchair and when I stood her up to walk to the van she was limping on her left foot. When she got back to the group home I			

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	assisted her into the house. I let her go to close the door and she attempted to walk and fell with the first step. I helped her up and sat her down in a chair an took off her coat and shoes. She sat and did not move until dinnertime when I stood her up and as soon as she stepped on her left foot she fell again. I helped her up to the dinner table so she could eat then I called the service coordinator to ask her if it had been reported that she fell at the workshop that morning and she said no. She (SC) told me to do an incident report about her falls and that she would check on it the next day with the workshop staff and that [client A] had an appointment the next day and she would have the doctor check her out. Also [client A] has fallen once prior to this back in November. When things happen at the workshop (day service) there is no communication between the group home and workshop as to what happens and what took place and what the end result is...During the week when she is at home she rarely has any accidents on herself except at night when she is asleep at night. Workshop staff says that she has an accident just about everyday on herself. Wen I picked her up at the workshop on Feb. 25, 2013 the staff that brought her out said that [client A] had an accident on herself and that she kept grabbing at her shoe. When I put her to bed Monday night (02/25/13) her left			

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	foot looked fine, but when we were at the hospital (02/26/13) and I was getting her undressed I noticed bruises on the bottom of her feet and had them do an x-ray and that's when they found it to be broken or fractured toes on her left foot. I honestly think that what ever happened it happened at the workshop. On Monday night (02/25/13) when I put her to bed I looked at her foot and it appeared to be fine but as I touched in certain places like the ball of her foot she would snatch her foot away from me." GH staff #1 failed to call the nurse on 02/25/13 to inform her of the falls, or client A's change in status, from when she saw her the morning of 02/25/13, to when she came home from day service on 02/25/13 in the PM. 03/06/13: Service Coordinator written statement indicated, "...I contacted [HST]. [HST] informed me that she has not been informed from any staff that [client A] has fallen. She did state that when it's time for medication, [client A] refuses to walk so the staff gets (sic) a wheelchair and pushes her to take her medication...." 03/07/13: SC Addendum indicated, "The 02/26/13 appointment was made due to physical issues. Wanted to get her checked out because she was having difficult (sic) using left hand & urinating on herself and refusing to do anything.			

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	On 02/25/113 Day Services wanted a UTI cup because she [client A] kept urinating on self at day service. [HST] was the person requesting the cup, but never did test because of doctor's appointment. There is no Incident Report stating this information." An Incident/Accident Report dated 02/25/13 and timed at 4:50 PM and 7:45 PM written by GH staff #1 indicated, "Client was limping when I picked her up from the workshop and when we got to the group home, she was not putting any weight on her left foot and fell when she tried to twice yesterday evening." The form contained the questions, "What did you do about this Incident/Accident?" GH staff #1 wrote, "called the service coordinator and did an incident report." GH staff #1 did not contact the nurse to report the two falls or client A's inability to bear weight on her left foot. Client A's records were reviewed on 03/12/13 at 10:58 AM. Client A's ISP (Individual Support Plan) dated 01/14/13 indicated she was at risk for falls and had a fall risk plan. The risk plan indicated, "...Contact the Nurse for further instructions even if unsure an injury has occurred...." Client A's record contained the following dated documents:			

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	02/26/13: Cumulative Medical Record indicated, "Admitted to [hospital]." The Hospital Record contained the following dated documents: 02/26/13: X-Ray Report - Foot/complete - Impression: Nondisplaced fractures involving the bases of the second, third and fourth metatarsals. There is mild impaction of the fracture fragments." 02/27/13: History and Physical indicated, "This is a patient I saw yesterday in my office and sent to the emergency room because the patient's caregiver told me that she was having some problems getting up and walking. She was also feeling somewhat weak on the left side, so she was admitted for further evaluation...The patient was admitted for further evaluation and now the patient was thought to have left ankle fracture on an x-ray of the ankle, which was a nondisplaced fracture involving the base of the second, third, and fourth metatarsals. There is mild impaction of the fracture fragment also. The patient is admitted for further evaluation...Impression: This is a ...patient who has several problems: 1. A left ankle fracture. 2. Left-sided weakness. It could be a stroke versus cervical degenerative joint disease related.			

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	Recommendation: My recommendation is to look at the MRI (Magnetic Resonance Imaging) of the brain and cervical spine, and then for the ankle fracture the patient is going to be seen by an orthopedic doctor." 02/27/13: Podiatry Consult Note: "This is a [age] female with non displaced fractures of the left foot...The 2nd metatarsal appears to be impacted at the fracture site and it is non displaced. It is an unstable fracture but will do well conservatively if the patient is non weight bearing for 6-8 weeks. 03/03/13 - PT Evaluation indicated client A was bed ridden and weight bearing status was non-weight bearing. The evaluation indicated follow-up PT was required and "Other Goal: To maintain functional ROM (Range of Motion of LEs (Lower Extremities). To assist in pt's positioning to prevent pressure ulcers development...." 03/04/13: Rehabilitation Evaluation/Preadmission Screening For Rehab Admission: "History of Present Illness: "...admitted on 02/26/13 for possible new CVA (Cerebrovascular Accident) (stroke). He referred the patient to the emergency room where she was evaluated, noted to have right			

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	fullness leg erythema (redness of the skin) with some swelling but had neuro exam was unremarkable. She had an x-ray of that right (sic) foot (left) area that demonstrated some multiple fracture of the metatarsals. She was however admitted for TIA (Transient Ischemic Attach) (loss of blood flow to a part of the brain) rule out CVA...Patient was referred to me for rehabilitation evaluation and further rehabilitation management because the patient was weak and not able to walk and not able to do activity of daily living...This patient does not meet rehab admission criteria. Discharge plan: home with family. The patient requires: Physical Therapy, Occupational Therapy and Speech Therapy...." 03/06/13: Discharge Summary: "Admit date: 02/26/13. Admitting Diagnosis: Cellulitis. Discharge Diagnosis: Multiple L (left) metatarsal (toe) fractures. Treatment & Course in Hospital With Complications If Any: Pt (patient) was admitted and orthopedic consultation made, and recommendations carried out. Pt has done [not legible] and now has appropriate immobilization device to her left foot and will be dc (discharged) with home health PT/OT (Physical Therapy/Occupational Therapy) at home. Disposition: DC to group home. Discharged 03/06/13." Client A was			

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	discharged with a prescription order from the hospital ordering PT/OT therapy. The hospital faxed the group home instructions which indicated, "will need OT/PT for home. Staff to transport at 6:00 PM." 03/06/13: Cumulative Medical Record indicated, "Discharged from [hospital]. Returned to group home." 03/07/13: Cumulative Medical Record indicated, "Writer (contract nurse) arrived at group home to assess patient...Pain noted to bilat (bilateral) (both) feet...Boot applied to L (left). Assist with transfers by DSP (Direct Support Staff)...N.O. (New Order) for PT/OT Therapy. The QMRP (Qualified Mental Retardation Professional) was interviewed on 3/11/13 at 6:06 PM. The QMRP indicated the nurse had seen client A in the home the day after she was discharged from the hospital. She indicated the nurse did not leave any instructions on how staff were to transfer (non weight bearing repositioning) and care for client A and her fractures. She indicated the hospital discharge information did not provide any information for transfers either. She indicated she had been contacted by the hospital prior to discharge and the hospital indicated client A had fractures			

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	on both the left and right sides and was not to bear weight. She indicated client A needed OT and PT appointments upon discharge and the nurse had not arranged those yet. She indicated she received no written instructions from anyone on how client A should be transferred, bathed or toileted and she developed a written "How to Perform a Two-Person Transfer From a Wheelchair" after watching a video given to her by the agency training department since no written policy/procedure existed. An interview with the RN (Registered Nurse) was conducted on 03/13/13 at 12:22 PM. The RN indicated staff should have contacted the nurse when the client arrived home on 02/25/13 when she was limping. She further indicated there were numerous incidents that night which should have alerted the staff to call the nurse. She indicated staff were to contact the nurse when the client has a change of status. Client A had a change of status when she arrived home limping after day service, when she fell twice, when she would not bear weight on her foot and when she pulled her foot away when staff touched it. The RN indicated day service should have reported the problems with client A's left side to the nurse as in could indicate she might have a stroke. She indicated staff did not have to know what			

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	was wrong with the clients, they were to simply report a change. Day service and group home staff neglect to report those changes. The RN indicated the nurse who saw client A in the group home the day after she was discharged failed to define how staff were to transfer (safely reposition/non weight bearing) client A or to obtain orders on how to transfer client A safely with her fractures. There were no instructions for staff regarding client A's care regarding bathing, toileting, bed or transfers from one place to another. The nurse neglected to ensure client A's needs were met by obtaining PT/OT Therapy. The RN indicated based on the information surrounding the facts on 02/25/13 client A should have been seen by a medical person on that day and not waited until a scheduled appointment the next day. She further indicated if there were any questions in the hospital discharge information from a verbal telephone call (to the QMRP) then the nurse should have clarified the information as to where there were fractures on the left, or on the left and right feet. An interview with the RN (Registered Nurse) was conducted on 03/14/13 at 10:22 AM. The RN indicated client A was scheduled for OT/PT on 03/27/13 at 10:30 AM.			

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	3. On 03/11/13 at 4:50 PM a record review of the Group Home March 2012 MAR (Medication Administration Record), for client A, was completed and included the following information: 03/07/13: Medication Change Form indicated client A had two new medications orders and one discontinued medication order. The form indicated, "Albuterol 0.083% Inhaler Solution. To inhale 3 ml (milliliter) via nebulizer three times a day as needed. Contact nurse if less than 8 hours between a repeat dose. The form was typed and the RN's name was typed at the bottom. The form also indicated, "Please fax a copy of the revised MAR for the nurse to review." 03/2012: March 2013 MAR for client A contained a hand written order, "Albuterol 0.083% Inhaler Solution - Inhale 3 ml via nebulizer 3 times a day as needed - 03/07/13" The MAR did not define the "as needed" and what condition/problems were to exist before the medication should be used. An interview with the RN (Registered Nurse) was conducted on 03/13/13 at 12:22 PM. The RN indicated the MAR should have contained the specific			

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	information on when the PRN was to be used. She indicated staff needed to be directed for its need and use by the RN. 4. Client A's records were reviewed on 03/12/13 at 10:58 AM. Client A's record contained the following dated documents: 02/07/13: Cumulative Medical Record (notes regarding client medical condition, written by direct care staff, nurse, physician and any medical providers) indicated, "Received report from day services that [client A] urinated on herself a couple (sic) times yesterday. U/A (urine test) being done." The entry was signed by LPN #2 on her last day of employment. The next entry was dated 02/21/13 and indicated, "[Client A] refused neuro (neurology) follow-up appointment today. Rescheduled for 03/07/13." 02/07/13: Order from MD (Medical Doctor) for Urinalysis with C & S (Culture & Sensitivity) if indicated. Dx (diagnosis) UTI (Urinary Tract Infection). 02/12/13: Order from client A's MD indicated the lab results (UA) was, "Abnormal but not significant - Recommendations: Push p.o. (oral) fluids if not on any fluid restriction." Client A's record did not indicate the nurse reviewed			

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	this order or carried out this order. The record contained no documentation by a nurse related to this order. An interview with the RN (Registered Nurse) was conducted on 03/13/13 at 12:22 PM. The RN indicated she was out of the office on medical leave from 02/13/13 to 03/04/13. She indicated there was no nursing service available to the agency from 02/13/13 to 02/19/13. This federal tag relates to complaint #IN00122535. This deficiency was cited on 01/28/2013. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			

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W000368	483.460(k)(1) DRUG ADMINISTRATION The system for drug administration must assure that all drugs are administered in compliance with the physician's orders. Based on record review and interview, the facility failed for 1 of 2 sampled clients (client A), to ensure PRN (as needed) medication were administered as ordered by the physician and failed to ensure medication order changes were implemented. Findings include: On 03/11/13 at 4:50 PM a record review of the Group Home March 2013 MAR (Medication Administration Record) for client A was completed and included the following information: 03/07/13: Medication Change Form indicated client A had two new medications orders and one discontinued medication order. The form indicated, "Discontinue Calcium 600 mg (milligram) Plus Vit[amin] D 400 iu (international units) one tablet twice a day. The form was typed and the RN's name was typed at the bottom. The form also indicated, "Please fax a copy of the revised MAR for the nurse to review." 03/2012: March 2013 MAR for client A contained a typed order for the Calcium. Under the directions for administration and hand written was, "3-7-13 D/C (discontinue)." The Calcium was initialed as given on 03/07/13 - for two doses, 03/08/13 - for two doses, 03/09/13 for two doses and 03/10/13 for one dose. Six doses were administered after the 03/07/13 order to discontinue the medication. An interview with the RN (Registered Nurse) was conducted on 03/13/13 at 12:22 PM. The RN	W000368	The Community Service Nurse will retrain the DSP's on how to properly assess and administer PRN medications. To ensure further compliance the nurse will visit group home monthly for three months and quarterly thereafter. The monitoring error was not assuring the medications were discontinued. The change in procedure is that the DSPs will line through the remainder of the month for discontinued medications and fax MAR to the nurse to assure it is done and is correct. The discontinued medication will be brought in to the Health Care clerk. The nurse will initial the faxed in MAR and give to the clerk. The clerk will double check that both are completed. This document will be filed and held for three months to ensure system is working.	04/12/2013

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	indicated medications that are not given as prescribed are considered medication errors as staff are not following the physician's orders. This federal tag relates to complaint #IN00122535. This deficiency was cited on 01/28/2013. The facility failed to implement a systemic plan of correction to prevent recurrence. 9-3-6(a)			